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How Do Professionals Portray Adolescents' Resilience in Residential Care? A Qualitative Study

Micaela Pinheiro | Eunice Magalhães | Joana Baptista

CIS-Iscte, Instituto Universitário de Lisboa (ISCTE-IUL), Lisbon, Portugal

Correspondence: Micaela Pinheiro (micaela_pinheiro@iscte-iul.pt)

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ABSTRACT

Adolescents in residential care may achieve positive outcomes despite previous adverse experiences. However, literature focuses more on negative outcomes than resilience. Supportive relationships between professionals and adolescents in residential care are key to ensuring resilience in adolescents. Therefore, professionals' perspectives need to be explored. This study aimed to identify professionals' perspectives on resilience factors among adolescents in residential care. Fifteen semi-structured interviews were conducted with a sample of female professionals (aged 23–51 years old; $M = 35.47$, SD = 8.06) working in three Portuguese residential care facilities. Professionals outlined resilience as the ability to overcome difficult situations, highlighting the support provided in residential care (e.g., emotional and instrumental), together with personal assets and adaptive coping as protective factors. Also, collaborative approaches between services and significant figures (e.g., family, school and residential care) were reported. This study offers theoretically new insights about the resilience of adolescents in the childcare system, and practical implications are discussed.

1 | Introduction

Adolescents placed in residential care often present with a history of abuse or neglect, which has been linked to an increased risk of developing mental, emotional and behavioural difficulties (Assouline and Attar-Schwartz 2020; Magalhães and Calheiros 2020), compared to those who live with their families (Roache and Mc Sherry 2021). However, despite past traumatic experiences, adolescents in residential care may exhibit positive adaptation and resilience outcomes (i.e., low psychopathology and high well-being and competence) (Pinheiro et al. 2021). Resilience can be broadly conceptualized from two perspectives: (1) it can be defined as a personality trait or individual attribute (Goldstein and Brooks 2005; Wagnild and Young 1993), or (2) it can be defined as a dynamic process in which multiple factors may interact and explain how individuals adapt positively in the face of adversity (Luthar and Cushing 1999; Masten 1999). The *resilience portfolio model*, anchored in this second perspective, provides a comprehensive theoretical framework for understanding positive adaptation following violence or trauma (Grych et al. 2015).

The *Resilience Portfolio Model* (Grych et al. 2015) takes a positive psychology perspective (i.e., understanding healthy functioning involves identifying the strengths that enhance individuals' psychological health) and posits that a set of protective factors (i.e., *assets*, *resources*, and *appraisal and coping behaviour*) may positively impact individuals' ability to adjust positively. According to this model, *assets* are individual characteristics that include regulatory strengths (e.g., self-regulation and

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cognitive skills), interpersonal strengths (e.g., forgiveness and empathy) and meaning-making strengths (e.g., religiosity and beliefs). *Resources* are external factors that include supportive relationships from family, friends or school, as well as environmental factors (e.g., school climate and neighbourhood), and *appraisals and coping behaviour* are strategies that help individuals respond to stressful situations (Grych et al. 2015). Based on this framework, the set of protective factors represents a unique resilience portfolio that enables healthy functioning, indicating low symptoms and high levels of well-being, competence or positive affect (Grych et al. 2015).

The literature involving adolescents in residential care shows that individual characteristics such as self-regulation, cognitive skills, or empathy and contextual factors such as supportive relationships (from family and staff in residential care) are positively associated with their psychological health (e.g., fewer symptoms, greater well-being and competence) (Pinheiro et al. 2021). However, the literature has mainly focused on adolescents' self-reports through quantitative designs focused on the relationship between risks, protective mechanisms and happiness (e.g., Maurović et al. 2014) and/or on the role of resilience resources in the psychological problems of adolescents in residential care (e.g., Segura et al. 2017). Furthermore, although several studies have used qualitative approaches to explore resilience in residential care from the professional's perspective (e.g., Malindi and MacHenjedze 2012; Nourian et al. 2016; Pienaar et al. 2011; Sulimani-Aidan 2018), theoretically driven studies are still lacking. Our study uniquely contributes to this field by extending the resilience portfolio model (Grych et al. 2015) by gathering evidence in the residential care context that may enable us to identify missing components of the resilience portfolio, which might be context specific. We seek to bridge theory and experience, offering a theoretically informed but situated understanding of resilience in residential care.

To achieve this therapeutic milieu in residential care, involving professionals in research is very important, given that their practices are critical to young people's recovery, and these practices are influenced by their beliefs and representations (Calheiros et al. 2011). Professionals' practices such as being empathic and providing emotional and tangible support seem to foster quality relationships with young people (Pinheiro et al. 2022). For this reason, the present study aimed to provide an insightful and innovative understanding of how professionals (including caseworkers and team directors) in generalist residential care portray adolescents' resilience.

This study was based on generalist residential care facilities aimed at addressing the psychological and basic needs of young people who were placed in residential care for protective reasons. In Portugal, as opposed to many European countries, residential care is the most common form of out-of-home care to protect children and adolescents who have been removed from their family environment (96.4%, Social Welfare Institute [ISS] 2023). The most recent statistics on young people in out-of-home care in Portugal reveal that 6347 children and adolescents were placed in residential care in 2022, of whom 84.1% ($n = 5344$) were placed in generalist residential care facilities and the others in specialized ones (e.g., 122 young people in therapeutic residential care and 164 young people in residential care facilities to foster their autonomy). Over half of these young people in residential care are male (52%) and adolescents (ages ranged 12–17; 51%), and around 30% show behavioural problems (ISS 2023). Considering the complex needs of young people in residential care, these settings must be able to provide quality services and professional practices that enable them to recover adaptively (Calheiros et al. 2011; Pinheiro et al. 2022).

Therefore, the present study aims to identify professionals' perspectives on the protective factors associated with positive adaptation for adolescents living in Portuguese generalist residential care and is anchored on a postpositivist paradigm of qualitative research (Creswell 2013; Guba and Lincoln 1994).

2 | Methods

2.1 | Participants

A sample of 15 female professionals from three residential care facilities participated in this study (age range 23–51 years old; $M = 35.47$, $SD = 8.06$). These three facilities only have female professionals in their teams, and for that reason, our sample did not include male participants. Over half of the participants were married (53.3%) and had completed a bachelor's degree (66.7%), and 33.3% had completed a master's degree. Concerning professionals' roles in residential care settings, 86.7% were caseworkers (i.e., psychologists and social workers), and 13.3% were team directors. These different professionals (i.e., caseworkers and team directors) were included in this study as they maintain regular and direct contact with the adolescents in residential care. The working time spent in residential care ranged from 1 to 14 years ($M = 5.73$; $SD = 4.62$). Considering the residential care settings, all participants worked in mixed settings (i.e., including both girls and boys), hosting between 17 and 42 young people during the data collection moment.

2.2 | Materials

2.2.1 | Socio-Demographic Questionnaire

Professionals completed a socio-demographic questionnaire that included a set of questions regarding personal and professional information, such as sex, age, marital status, education, role in residential care, time in service, type of residential setting and the number of young people placed in the current residential setting.

2.2.2 | Semi-Structured Interview

Grounded in the *Resilience Portfolio Model* (Grych et al. 2015), a semi-structured interview script was developed that contained four thematic sessions: (1) introduction, (2) factors explaining resilient trajectories of adolescents in the general population, (3) factors explaining resilient trajectories of adolescents in residential care and (4) conclusions. The first thematic section aimed to identify professionals' perspectives on the concept of resilience and positive outcomes (e.g., 'If you were asked to explain what the concept of resilience is, what would you say?' and 'How do

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we perceive that a young person who has experienced negative events is still doing well/is resilient?'). To identify the similarities and specificities of resilient factors in and out of care, the second thematic section aimed to identify professionals' perspectives on protective factors for the positive adaptation and resilience of adolescents in the general population (e.g., 'When you think about a resilient young person, what do you think has contributed to his/her resilience?'), followed by a third section that focused on protective factors for adolescents in residential care (e.g., 'When you think about a resilient young person in residential care, what do you think has contributed to his/her resilience?'). Finally, professionals were asked to identify which factors were the most meaningful for adolescents' mental-health outcomes in residential care (e.g., 'Regarding the factors you identified earlier, which are the most determinant factors for adolescents in residential care?'). The interview was concluded by presenting a debriefing and addressing any questions or comments that might have arisen from the care workers.

2.3 | Procedures of Data Collection and Analysis

This study was approved by the ethical committee of the researchers' university (Ref. 105/2021). Following this approval, participants were selected using a convenience sampling approach from three Portuguese residential care facilities (i.e., generalists' residential care settings, which are nontherapeutic care or juvenile corrective settings). Formal invitations, by e-mail, were sent to the selected residential care settings to invite them to participate in the study. Before data collection, the first author virtually met with the directors (using the Zoom app) to explain the main objectives of the study and the inclusion criteria of participants: (1) professionals in residential care (i.e., caseworkers and team directors) and (2) those who understood Portuguese.

Professionals were informed about the study's conditions (objectives, duration and audio recordings) and ethical issues, such as the voluntary nature of their participation, the right to interrupt at any moment and data confidentiality, which means that their identity would not be disclosed when transcribed, analysed and reported. Additionally, the participants were informed that the audio file will be deleted after the content has been transcribed. After reading the informed consent form, the participants stated that they understood all the information and agreed to participate. The first author conducted individual interviews in the participants' language (i.e., Portuguese) in each residential setting. First, participants responded to a socio-demographic questionnaire. Then, the semi-structured interview was conducted, and the same structure and sequence of the questions were followed. Data were collected between March 2022 and June 2022. The duration of the interviews ranged from 11 to 48 min.

Data analysis was conducted using *IBM SPSS software* (Version 28) to describe the participants' socio-demographic characteristics. The content analysis approach (Krippendorff 2018) was conducted using *MAXQDA software* (Version 22) to analyse qualitative data and coding categories. More specifically, the data analysis process involved (1) *decontextualization* (i.e., knowing the data and defining the units of analysis), (2) *open coding* (i.e., creating macrocategories, categories and subcategories, which were associated with a description) and (3) *recontextualization* (i.e., reporting the analysis process and examining how these categories related to the broader context of each participant's narrative). A mixed-analytic approach was adopted to code the material. To identify and organize the categories, an inductive codification (i.e., data-driven) was first applied, followed by a top–down strategy (i.e., theory-driven) based on the theoretical framework (Krippendorff 2018). The coding categories were created to address the research aims, specifically considering the content from the different sections of our interview, as these sections provided context for qualitative content. Furthermore, data were gathered and reported taking into consideration the 32-item checklist of COREQ, which was created for reporting qualitative research (i.e., interviews or focus groups; Tong et al. 2007) in terms of three domains: (1) research team and reflexivity, (2) study design, and (3) data analysis and reporting (see Table S1 for more information).

To assess the reliability and validity of the analysis (Krippendorff 2018), data analysis included a co-codification of a percentage of all material, and frequencies of coded data were quantified and reported. A thorough discussion of all the categories among the three researchers, the use of relevant examples from the accounts of care workers and the independent researcher's co-coding of 30% of the data all served to ensure the validity and reliability of the coding categories that emerged. The *Cohen kappa* coefficient was used to assess intercoding agreement (Landis and Koch 1977), and a perfect agreement was obtained (kappa = 0.963). The meaning units deemed to be particularly illustrative for each category were chosen, along with quotes from participant remarks that were coded for qualitative analysis (Krippendorff 2018). The number of professionals who reported the category (n) and the frequency of meaning units for each category (f) were used to depict the results.

3 | Results

Data analysis resulted in eight macrocategories, 40 categories and 35 subcategories. All these categories are listed in Table 1, but for parsimony reasons, we will merely detail the most prevalent categories (i.e., reported by more than three participants) in the text.

3.1 | Resilience Conceptualization and Resilience Outcomes

When the *resilience concept* was explored, seven categories were identified. Most of our participants defined resilience as the capacity to *overcome* difficult situations (e.g., 'I would say that resilience involves the ability to overcome difficult situations'; P1, 26 years), followed by the capacity to *cope with problems* (e.g., 'I would say that it is the ability of any individual to solve problems'; P6, 36 years) and *post-traumatic growth*, suggesting individuals' personal growth after a life crisis or traumatic event (e.g., 'It is the ability we have to meaningful personal development after a situation or stress, trauma'; P5, 48 years).

Regarding the *resilience outcomes*, four categories were identified in the current study: *competence*, *psychological well-being*, *emotional and behavioural adaptation*, and *sense of belonging*.

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TABLE 1 | Macrocategories, categories and subcategories about the resilience concept and protective factors of adolescents' psychological health, through the lens of professionals in residential care.

Macrocategory	Category	Subcategory
Resilience concept	Overcome ($n = 9$; $f = 10$)	
	Cope with the problems ($n = 6$; $f = 6$)	
	Post-traumatic growth ($n = 4$; $f = 4$)	
	Adaptation ($n = 3$; $f = 3$)	
	Acceptance ($n = 2$; $f = 2$)	
	Do not give up ($n = 2$; $f = 2$)	
	Persistence ($n = 2$; $f = 2$)	
Resilience outcomes	Competence ($n = 13$; $f = 29$)	Academic competence ($n = 9$; $f = 9$)
		Social competence ($n = 6$; $f = 11$)
		Straight on ($n = 5$; $f = 5$)
		Self-regulation ($n = 2$; $f = 2$)
		Confidence ($n = 1$; $f = 1$)
		Readiness ($n = 1$; $f = 1$)
	Psychological well-being ($n = 7$; $f = 11$)	Positive meaning-making ($n = 4$; $f = 5$)
		Purpose in life ($n = 4$; $f = 4$)
		Autonomy ($n = 1$; $f = 1$)
		Self-acceptance ($n = 1$; $f = 1$)
	Emotional and behavioural adaptation ($n = 5$; $f = 6$)	Adaptative behaviour ($n = 2$; $f = 2$)
		Positive adaptation ($n = 3$; $f = 4$)
	Sense of belonging ($n = 1$; $f = 1$)	

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TABLE 1 | (Continued)

Macrocategory	Category	Subcategory
Resources	Sources of social support ($n = 15$; $f = 112$)	Family ($n = 15$; $f = 39$)
		School ($n = 15$; $f = 41$)
		Community ($n = 10$; $f = 17$)
		Peers ($n = 8$; $f = 15$)
	Type of support provided ($n = 15$; $f = 92$)	Receiving emotional support ($n = 15$; $f = 64$)
		Receiving instrumental support ($n = 12$; $f = 28$)
	Involvement in extracurricular activities ($n = 12$; $f = 28$)	
Assets	Individual attributes ($n = 11$; $f = 87$)	Self-qualities ($n = 11$; $f = 23$)
		Personality ($n = 8$; $f = 21$)
		Communication skills ($n = 7$; $f = 24$)
		Motivation ($n = 4$; $f = 9$)
		Optimism ($n = 3$; $f = 10$)
	Life experience and purpose ($n = 7$; $f = 8$)	
	Regulation skills ($n = 5$; $f = 11$)	
	Coping—Problem-solving ($n = 2$; $f = 3$)	
Specific resilience portfolio of adolescents in out-of-care contexts	Receiving financial support ($n = 1$; $f = 1$)	
	Critical thinking and proactivity ($n = 4$; $f = 5$)	
	Be kind and extrovert ($n = 2$; $f = 3$)	
	Be autonomous ($n = 1$; $f = 1$)	
	Cognitive skills ($n = 1$; $f = 1$)	

(Continues)

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TABLE 1 | (Continued)

Macrocategory	Category	Subcategory
Specific resilience portfolio of adolescents in residential care	Type of support provided in residential care ($n = 14$; $f = 94$)	Emotional support in residential care ($n = 14$; $f = 60$)
		Instrumental support in residential care ($n = 10$; $f = 34$)
	Staff characteristics and behaviours in residential care ($n = 13$; $f = 79$)	
	Sources of support in residential care ($n = 12$; $f = 25$)	Staff in residential care ($n = 10$; $f = 12$)
		Peers support in residential care ($n = 8$; $f = 13$)
	Ecological interventions (residential care–family–school–community) ($n = 11$; $f = 30$)	
	Residential care resources ($n = 9$; $f = 17$)	
	Frequent contact with relatives ($n = 8$; $f = 14$)	
Characteristics of adolescents in residential care	Individual attributes ($n = 12$; $f = 28$)	Adaptability ($n = 6$; $f = 13$)
		To be cooperative ($n = 3$; $f = 3$)
		To be responsible ($n = 3$; $f = 1$)
		To be curious ($n = 1$; $f = 2$)
	Coping ($n = 5$; $f = 9$)	Help-seeking ($n = 2$; $f = 4$)
		Meaning-making ($n = 2$; $f = 3$)
		Focus on schools' tasks ($n = 1$; $f = 1$)
		Humour ($n = 1$; $f = 1$)
	Knowledge about the process in residential care ($n = 2$; $f = 2$)	
Meaningful factors of resilience	Individual attributes ($n = 7$; $f = 8$)	
	Ecological interventions ($n = 6$; $f = 9$)	
	Family ($n = 6$; $f = 7$)	
	Community ($n = 3$; $f = 3$)	
	Extracurricular activities ($n = 1$; $f = 1$)	
	Peers ($n = 1$; $f = 1$)	
	Residential care context ($n = 1$; $f = 1$)	
	School ($n = 1$; $f = 1$)	

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Specifically, our participants suggested that *competence* involves different sides of capabilities, such as *academic competence* (e.g., 'For example from the school part, right? If you are a kid who, despite difficult situations, manages to maintain a positive school career, manages to show satisfactory results, I think this is one of the factors in which he shows a little bit of that resilience.'; P3, 40 years), *social competence* (e.g., 'When they manage to create interactions outside the home context when friends are no longer just those who live in residential care and who have common stories. When they manage to bond with the community'; P14, 40 years) and the capacity to *move forward* (e.g., 'That they manage to move forward, sometimes the families end up not living up to expectations and, therefore, it leaves them frustrated, but when they manage to move forward, it is noticeable that they are being resilient'; P13, 38 years).

In terms of *psychological well-being*, our participants considered that it includes *positive meaning-making*, which means that individuals interpret situations and make sense of life events in an adaptative way (e.g., 'As I usually say to my colleague, so many bad things happened to him and when he tells his story and it's not an escape, it's not a denial, he turns what was bad into good'; P5, 48 years), and having a *purpose in life*, which means the adolescents' ability to guide their life and shape their goals (e.g., 'When we find an adolescent who has well-defined life goals, personal goals, whether professionally or socially'; P15, 23 years). Finally, the *emotional and behavioural adaptation* category includes being able to show a *positive adaptation* to the new reality or context in general (e.g., 'Everyone arrives here with a lot of baggage and, therefore, I think that when their path here proves to be favorable and they are adapting'; P13, 38 years).

3.2 | Resilience Portfolio

When examining the protective factors for resilient trajectories from the professionals' perspective, two macrocategories were found: *resources* and *assets* (Table 1).

Concerning the macrocategory *resources*, three categories were identified: *sources of social support*, *type of social support* and *involvement in extracurricular activities*. Specifically, our participants identified mostly elements from the *family* (e.g., 'I think the factors are essentially the people he has in his life, especially his family'; P1, 26 years) and the *school* (e.g., 'I think that school community has a fundamental and very important role'; P7, 51 years) as the most important sources of social support, even though the *community* (e.g., 'The entire surrounding community'; P6, 36 years) and *peers* (e.g., 'Their peer groups and having friends'; P12, 40 years) were also reported. Considering the *type of social support*, our participants stated that *receiving emotional support*, such as caring and attention (e.g., 'It has everything to do with the emotional aspect, with the safe haven, the lap'; P8, 26 years), and *receiving instrumental support*, such as getting information and help to meet tangible needs (e.g., 'Rules and routines well-defined'; P15, 23 years), were the most expressive types of support. Finally, the *involvement in extracurricular activities*, such as football, theatre or painting, to learn social skills and have fun moments, was also identified as a protective factor (e.g., 'If they had sports activities if they were children who had cultural activities'; P6, 36 years).

Regarding the *assets*, four categories were identified: *individual attributes*, *life experiences and purpose*, *regulation skills* and *problem-solving coping*. *Individual attributes* include a set of personal characteristics that might enable adolescents to positively adapt and show positive psychological health. Specifically, this includes *self-qualities* such as self-esteem, self-knowledge or self-confidence (e.g., 'I believe that a big part of this is the issue of trust, and when people have faith in themselves, they are able to trust others, but if they don't have faith in themselves, they will never be able to have faith in anyone else'; P8, 26 years) or *personality* traits (e.g., 'I think this has a lot to do with each one's personality. The personality and how we are part of our "self" is very decisive in this matter of resilience and adaptation'; P3, 40 years). Moreover, adolescents' *communication skills*, which comprise their ability to convey or share ideas and feelings with others (e.g., 'I think it also has a lot to do with communication'; P6, 36 years), and high levels of *motivation* to take action (e.g., 'Kids who have motivation, here some ambition and motivation to go further'; P3, 40 years) seem to be perceived by professionals as important assets to achieve psychological health.

Finally, *life experience and purpose*, which refers to a deep sense of meaning or intention in life (e.g., 'When an adolescent doesn't have a dream and doesn't believe in something, there is no resilience and he thinks "ok, so what? Where am I going to get to?" I think you have to have a purpose because without a purpose, I don't think it's possible.'; P11, 37 years), as well as revealing *regulation skills*, which means the adolescents' ability to control their emotions (e.g., 'I think young people have to be able to manage the internal conflicts (frustration) very well'; P5, 48 years), were identified by our participants as individual protective factors.

3.3 | The Specific Resilience Portfolio of Adolescents in Out-of-Care Contexts

In addition to the factors identified above, professionals in this study consider that adolescents who do not live in residential care have several other specific protective factors. As such, five categories were identified: *critical thinking and proactivity*, *be kind and extrovert*, *be autonomous*, *cognitive skills* and *receiving financial support* (Table 1). Adolescents' *critical thinking and proactivity* was the most prevalent category, and it involves their ability to evaluate and make a judgement about a situation (e.g., 'The ability to occasionally rise above the pressure and think independently rather than in the interests of the group is difficult in today's contexts'; P14, 40 years).

3.4 | The Specific Resilience Portfolio of Adolescents in Residential Care

In addition to the resilience portfolio previously identified, professionals have stated that adolescents in residential care also present protective factors related to the *residential care context* and to their personal attributes: *characteristics of adolescents in residential care* (Table 1).

The macrocategory *residential care context* included six categories: *type and sources of support in residential care*, *staff characteristics and behaviours*, *ecological interventions*, *residential*

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care resources and *frequent contact with relatives*. Specifically, our participants reported that the *emotional support* provided by staff and peers in residential care (e.g., 'I think that what can provide a good adaptation here is the close relationship that one can have both with the adults in the group home and with peers'; P9, 31 years) and the *instrumental support* in residential care, through help to establish routines and limits (e.g., 'Having important rules and we always say that rules are very important for us to live in society. We may not agree 100% with them, but we must do them and that's very important to them. Realize that there is a routine'; P15, 23 years), are the most relevant types of support in residential care to foster adolescents' resilience. Our participants considered that *staff characteristics and behaviours* might be protective if they comprise staff skills such as being helpful, empathic, available, and responsive and practices such as meeting adolescents' emotional and tangible needs (e.g., 'But for me, it's really the ... oh the empathy also helps a lot. Be empathetic with the adolescent and talk about everything he wants to talk about'; P6, 36 years). Moreover, the *support in residential care* provided by *staff* (e.g., 'All of us, but perhaps the caregivers have a role here because they are the ones who are here in the morning, afternoon and evening'; P7, 51 years) and by *peers* (e.g., 'The peers, the connections they create, inside and outside, but inside is also very important because they sometimes create friendships for life here and it is those friends who help them to cope, because residential care has many ups and downs, and friends inside the house help to cope with all of this'; P14, 40 years) was also recognized as protective of adolescents' resilience in residential care.

Furthermore, a collaborative approach between different stakeholders from various developmental contexts (i.e., family, school, residential care and community) was highlighted by our participants as a resilience resource—*ecological interventions* (e.g., 'I think that the relation between all the elements, between the group home and family, group home and school, group home and sports, group home and cultural activities, whatever it may be, there has to be a lot of communication and a lot of involvement from both parts and we have to analyze the objective for the same, it is not each paddling for their path'; P6, 36 years).

In addition, a set of *residential care resources* were identified, such as its structure and dynamics (e.g., 'I think that the structure of the residential care setting itself, the physical and dynamic structure of the home can also have an impact on how they will deal with the issues that arise later'; P12, 40 years) as well as the *frequent contact with relatives*, which means that keeping contacts between adolescents and their birth family or other relatives is particularly protective to a resilient trajectory in residential care (e.g., 'When the family is present, that they are interested, that they want to come and be with them, that they are concerned, that they call the care workers team to find out how they are doing, that they call the caregivers team in principle, these children are able to have stability at an emotional level and more assertive behavior here, in short, more positive'; P13, 38 years).

Finally, three categories were found for the macrocategory *characteristics of adolescents in residential care*, which encompass a set of distinctive traits and attributes that set one adolescent apart from another: *individual attributes*, *coping* and *knowledge of the process in residential care*. From the perspective of our participants, individual attributes such as their *adaptability* were highlighted as fostering adolescents' resilience, which means the ability of these adolescents to adapt effectively to a new condition (e.g., 'How themselves adapt to the residential care. They adapt to the routines of the home, to the rules that are imposed, that's it. I think these are also important factors'; P12, 40 years).

3.5 | Meaningful Factors of Resilience

Having previously identified and described the protective factors of resilience in residential care, professionals in this study highlighted that the most determining factors of adolescents' resilience are their *individual attributes* (e.g., 'I think they are their own. I think it is the work done directly with them on a psychological level. The characteristics they have and what can be worked on in this aspect'; P4, 37 years), followed by implementing *ecological interventions* (e.g., 'The most important factor, hm ... Maybe the system's proximity to families and young people. When I say the approach of the system, I am including the judge who decides and makes that decision, as well as the professionals who decide to remove the child from the family. Close'; P11, 37 years) and factors related to the adolescents' *family* (e.g., 'I think, without any doubt, the family'; P10, 32 years). These protective factors were pointed out by our participants as those particularly noteworthy to foster adolescents' resilience in residential care.

4 | Discussion

Using a qualitative approach, this study explored professionals' perspectives on the protective factors associated with positive adaptation of adolescents in residential care. To our knowledge, this is the first qualitative study guided by the *Resilience Portfolio Model* (Grych et al. 2015) that focused on professionals' perspectives in this specific developmental context. Overall, resilience was defined as the capacity to overcome adversity, emphasizing the protective role of individual and contextual factors such as personal assets, adaptive coping and residential care support (such as emotional and instrumental support). Additionally, ecological interventions between significant figures (e.g., family, school and residential care) and services were reported.

Regarding the concept of resilience, professionals defined it mostly as the ability to overcome difficult situations in life. This means that resilience occurs only in the face of adversity, and protective factors allow young people to rebound from adversity, which is critical to overcome and show healthy functioning (Hamby et al. 2018). Moreover, professionals pointed out that psychological health as an outcome (i.e., competence, psychological well-being, emotional and behavioural adaptation, and a sense of belonging) involves more than the mere absence of psychopathology, as it also includes well-being and competence. This finding suggests that healthy functioning, after exposure to adversity, is better conceptualized as a multidimensional concept (Grych et al. 2015), including both the presence of positive indicators of mental health and the absence of negative ones (Magalhães and Calheiros 2017). Nevertheless, the literature on victims of violence (and specifically, including young people in

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residential care) has explored resilience mostly as the absence of psychopathology, overlooking a more comprehensive approach that also includes the well-being side of health (Hamby et al. 2018; Magalhães and Calheiros 2017; Pinheiro et al. 2021).

Concerning the resilience portfolio, professionals proposed a set of protective factors at different levels (e.g., supportive relationships in and out of care and personal assets and coping strategies), suggesting that supportive relationships are particularly important for the adolescents in residential care. Supportive relationships have been widely acknowledged as a protective factor for healthy functioning given that they provide a secure relational context that might foster individuals' emotional security and regulatory strengths (Mota and Matos 2014; Riley 2011). Moreover, supportive relationships may buffer the negative consequences of traumatic events (e.g., abuse and/or neglect) (Cohen and Wills 1985; Lakey and Cohen 2000), which is particularly critical for adolescents in residential care, as they were often victims of such abusive and neglectful experiences (Indias et al. 2019). As such, supportive relationships in residential care might provide a critical therapeutic relational environment, including safer and more stable significant relationships (Izzo et al. 2020; Mota and Matos 2014). In fact, professionals' skills (e.g., being helpful and empathic) and supportive practices (e.g., meeting emotional and tangible needs) might raise positive adaptation and lower psychopathology (e.g., Aguilar-Vafaie et al. 2011, 2014; Erol et al. 2010; Maurović et al. 2014) by fostering adolescents' self-efficacy and self-regulation (Riley 2011). Thus, a *therapeutic milieu* that provides supportive relationships is critical, which calls for training and supervision of professionals in residential care to ensure that skilled staff (e.g., empathic and responsive) work in these contexts (Gonzalez-Mendez et al. 2021; Magalhães et al. 2023; Pinheiro et al. 2022).

Furthermore, delivering ecological interventions, which involve diverse services and professionals in the child care system together with birth families, was perceived by our participants as a resilience resource. Systemic, collaborative and ecological interventions (Bronfenbrenner and Morris 2006) can strengthen the resilience portfolio of adolescents in residential care, especially through quality relationships with significant others in different microsystems (e.g., home, school or other residential care facilities). These relationships are particularly important given the critical separations and losses these adolescents often experience (e.g., family and peers at school) (Calheiros and Patricio 2014; Magalhães and Calheiros 2017). As such, promoting stable relationships in care and supporting family-oriented practices that strengthen ties with the birth family (Geurts et al. 2012) simultaneously with an ecological and collaborative approach can improve child welfare outcomes, such as successful family reunification or the adolescents' transition to independent living.

In fact, the adolescents' psychological health in care may be positively affected by regular contact with their birth families (Attar-Schwartz and Fridman-Teutsch 2018), particularly when family reunification is planned. Also, these adolescents may benefit from the protective role of a quality relationship with teachers at school (Kirk and Day 2011; Rhodes et al. 2006) or with significant others in the community (e.g., peers) through involvement in extracurricular activities. Specifically, participation in extracurricular activities is associated with lower mental distress and greater emotional well-being (Caserta et al. 2016), particularly for adolescents who are exposed to traumatic experiences (Grych et al. 2015). Thus, adolescents' involvement in the community (e.g., through participation in extracurricular activities) would be guaranteed to provide greater young people's empowerment that might facilitate their transition from care to an independent life. Residential care contexts full of resources might provide better conditions for empowering adolescents through the protective role of supportive relationships with the staff (Rabley et al. 2014). In sum, in this study, professionals seem to acknowledge the value of ecologically oriented approaches in residential care, together with the individual characteristics of adolescents, which might facilitate resilience in these specific developmental contexts.

Finally, professionals revealed that having a greater repertoire of personal assets (e.g., adaptability, self-qualities, personality and communication skills) and adaptive coping strategies (e.g., help-seeking behaviours and meaning-making strategies) might be particularly useful for helping adolescents in residential care to thrive with adversity. Personal assets such as adaptability, personality traits and communication skills of adolescents in residential care were suggested by professionals as important protective factors in their resilience portfolio. These unique personal attributes might be important precursors of adaptation to the diverse challenges in their lives (e.g., rules and routines in care and placement challenges; Lukšík 2018). They may also help foster positive and quality relationships in care (Pinheiro et al. 2022), which in turn might positively impact their psychological health. In addition to these personal assets, coping strategies, such as help-seeking coping, meaning-making and humour, were highlighted by our participants in this study as particularly protective of resilience in residential care, compared to young people not in care. Professionals revealed that having a greater repertoire of adaptive coping strategies (e.g., help-seeking behaviours and meaning-making strategies) might be particularly useful for helping adolescents in residential care to thrive with adversity, more than for adolescents in the general population. Adolescents' ability to seek support might provide them with the necessary help to manage daily stress and problems or regulate emotional difficulties (Hiller et al. 2021). Furthermore, meaning-making strategies enable adolescents to assign significance and purpose to their lives when faced with stressful situations (Grych et al. 2015), whereas humour is often a type of reflective strategy that allows adolescents to have a more positive outlook and release from the situation (Führ 2002). These coping strategies were perceived by our participants as particularly important for young people in residential care (and not so important for those living with their families), which might suggest that these professionals acknowledge the critical role of previous adversity. Thus, interventions in residential care might provide opportunities for these adolescents to become more able to implement active and problem-solving coping strategies (Arslan 2017) and to achieve self-regulation skills, which are both important for reducing psychopathology and enhancing well-being (Nourian et al. 2016; Maurović et al. 2014; Segura et al. 2017).

Despite these innovative contributions, this study has some limitations. The present study only included female professionals; therefore, future studies might benefit from the

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inclusion of more gender-balanced samples if further residential care settings could be included. Moreover, this study was based on a convenience sample of 15 professionals from three generalist residential care settings. Also, future research should include the perspectives of professionals from therapeutic residential care settings, enabling the identification of factors that could be protective in contexts that address complex adolescents' mental-health needs. Furthermore, this study included residential care directors (who are responsible for the teams' coordination and management of adolescents' case plan) and case managers (who are only responsible for the adolescents' case plan management), but not caregivers. Caregivers are the frontline staff, and their perspectives are also critical to fostering resilience in residential care. Finally, further studies should include a more in-depth approach on how professionals conceptualize their own role in fostering resilience. This would provide critical insights into practice and training needs.

5 | Conclusion

This study expands the literature on adolescents' resilience in residential care by providing new theoretical insights from professionals' perspectives. Overall, the results show that resilience in care stems from the interplay between personal assets, coping, supportive relationships and ecological interventions. Particularly, this study sheds light on the critical role of the interplay between family, schools and residential care settings to provide supportive relationships that might strengthen adolescents' resilience outcomes. Therefore, adolescents in residential care may have a unique resilience portfolio that enables their healthy functioning in terms of both low symptoms and high levels of well-being and competence (Grych et al. 2015).

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Research data are not shared.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Table S1:** Thirty-two items checklist (COREQ) applied in this study (Tong et al. 2007).

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